VISION SOURCE®

## Patient Information

Patient Full Name: _____ Date: _____

Address: _____ City: _____ St: _____ Zip: _____

Phone: (Cell) _____ (Home) _____

Date of Birth: _____ Age: _____ Sex: _____ E-Mail: _____

Patient SSN: _____ Occupation: _____ Employer: _____

How did you hear about us? _____

**Reason for your visit:** Glasses Contacts Other: _____

## Ocular History

(**Y**ou **M**om **F**ather **S**ibling **G**rand**P**arent)

| | | | | | |
|---|---|---|---|---|---|
| Dry Eyes | **Y** | **M** | **F** | **S** | **GP** |
| Crossed Eyes | **Y** | **M** | **F** | **S** | **GP** |
| Iritis/Uveitis | **Y** | **M** | **F** | **S** | **GP** |
| Glaucoma: | **Y** | **M** | **F** | **S** | **GP** |
| Macular Degeneration | **Y** | **M** | **F** | **S** | **GP** |
| Diabetic Retinopathy | **Y** | **M** | **F** | **S** | **GP** |
| Cataracts | **Y** | **M** | **F** | **S** | **GP** |
| Blindness | **Y** | **M** | **F** | **S** | **GP** |
| Any Eye Surgery | **Y** | **M** | **F** | **S** | **GP** |
| Any Retinal Diseases | **Y** | **M** | **F** | **S** | **GP** |

## Patient Diabetic History

Pre-diabetic: **Yes** or **No**
Diabetic: **Yes** or **No**
Year of diagnosis:

What is your A1C:

Recent Blood Sugar:

## Patient Medical History

Please circle any that apply

| | | |
|---|---|---|
| High Blood Pressure | Asthma | Rosacea |
| High Cholesterol | COPD | Headaches |
| Thyroid | Emphysema | Multiple Sclerosis |
| Cardiovascular | Kidney Disease | Seizures |
| Cancer | Prostate Disease | ADHD |
| Surgery | Arthritis | Anxiety |
| Fatigue | Crohns Disease | Depression |
| Weight Loss | IBS | Anemia |
| Fibromyalgia | Reflux | Leukemia |
| Sinus | Eczema | HIV |

## Family Medical History

Circle any that apply (**M**om **F**ather **S**ibling **G**rand**P**arent)

| | | | | |
|---|---|---|---|---|
| Diabetes: | **M** | **F** | **S** | **GP** |
| High Blood Pressure: | **M** | **F** | **S** | **GP** |
| Cholesterol: | **M** | **F** | **S** | **GP** |
| Thyroid: | **M** | **F** | **S** | **GP** |

| | | |
|---|---|---|
| Smoke: | **Yes** | **No** |
| Former Smoker: | **Yes** | **No** |
| Alcohol: | **Yes** | **No** |
| **Daily or Occasional** | | |

How many hours on computer or digital devices:
**1-3** **4-8** **8+**

| | | |
|---|---|---|
| Are you sensitive to the sun? | **yes** | **no** |
| Do you have issues with glare? | **yes** | **no** |
| Are you concerned with blue light damage? | **yes** | **no** |

**OPTOS**: The doctor always recommends taking a high resolution photograph called Optos of the inside of the eye because it can detect eye diseases before they become serious. The copay is **$39** for the photograph and is not covered by the vision insurance.
Circle one : **yes to Optos (no dilation required)** **no photograph**

**If you choose NOT to do the retinal photograph**, we recommend a dilated exam to check the inside of the eye. The eye drops have some side effects of blurry vision and sensitivity to the light typically for 2-3 hours. Most people drive home but we recommend driving slowly.
Circle one: **yes dilate my eyes** **no dilation**

**MEDICATION LIST (include OTC)**: _____

**ALLERGIES TO DRUGS** (List): _____

# Acknowledgment of Notice of Privacy Practices

*Effective date of notice 01/01/2022*

Vision Source Greenspoint
12122 Greenspoint Drive
Houston TX 77060
281.875.5439

The law requires that Vision Source Greenspoint make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

**YES**: ____I was given the opportunity to read, have read or had explained to me Vision Source Greenspoint's Notice of Privacy Practice prior to any services offered.
**NO:** ___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible.

I authorize Vision Source Greenspoint to release my personal health information to the following individuals (typically a spouse, caretaker, or simply left blank):

_____ _____
_____ _____

My vision plan and/or medical plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:
**YES:** ___ I authorize the release of medical information to my vision and/or medical plan
**NO:** ___ I do not authorize release of medical information to my vision and/or medical plan
I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

_____ _____
Representative Signature Relationship to Patient Date

# Vision Source Greenspoint

Professional Policies 2022

All service fees which include but are not limited to exam fees, copays, contact lens exam copays, medical exams, special testing and are not refundable and **MUST** be paid in full at time of service. The only exception is the retinal photograph on a case by case basis.

**The dilated exam** is included in the routine eye exam at no charge if it is performed on the same exam date or scheduled within 30 days of the initial exam date.

**UNSATISFIED VISION:** You have within 30 days of the original order date to inform us If you are not fully satisfied with your glasses. If your frames are in new and "saleable" condition, we will credit the full amount of the FRAMES to use towards the purchase of a new frame or a refund credit in the form of a check. Frames in "un-saleable" condition will not be refunded. Ophthalmic lenses will have a 25% restocking fee.

**ANY FRAME, LENS, OR CONTACT LENS ORDER CANCELLED BY THE PATIENT BECAUSE OF BUYER'S REMORSE** will only be refunded 50% of the order if it has already been submitted to the lab/manufacturer.

**Payment arrangements:** will be determined on an individual basis and should be requested by the patient. As of 10/12/21 we will not order any glasses or contact lenses until we have received 100% payment.

**UNCLAIMED ORDERS:** We will contact you by phone, email, and mailing address for all orders. If the order is not picked up within 180, they will be removed from storage. No refund will be given. No exceptions.

**FRAME WARRANTY:** All frames automatically come with a one year warranty UNLESS it is a clearance frame indicated by a red marking and explicitly indicated on your receipt. Abuse or loss is **NOT** covered under warranty. Replacing frames under warranty have a $35.00 charge. Some Medicaid insurances may replace broken frames at no cost within 1 year of purchase date.

**LENS WARRANTY:** Lenses that are chipped or scratched can be replaced for $25 only once within 1 year of purchase date. Some Medicaid insurances may replace the lenses at no cost within 1 year of purchase date.

**USING YOUR OWN FRAME:** We are happy to adjust your own frame, repair your frames, and/or use your frames for your new order. We will do our best not to break your frames. However, if your frame breaks during this process, we are not held responsible, and we will not reimburse your frames for any reasons. You acknowledge that this is a risk that you are taking using your own frame and not using one of ours.

**I certify that the insurance information that is provided to this office is accurate. I understand I am financially liable for any deductible amount, co-insurance and non-covered services or any other balance not paid by my insurance company. If my insurance company denies payment, I agree to be personally responsible for payment. If I have no insurance, I understand that I am responsible for the entire balance of services and products provided.**

Patient/Guardian_____ Date_____

Printed Name _____